

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005051	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/04/2015
NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH		STREET ADDRESS, CITY, STATE, ZIP CODE 1701 N SENATE BLVD INDIANAPOLIS, IN 46202		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>The survey was for the investigation of one State hospital complaint.</p> <p>Complaint number: IN00163098 Unsubstantiated: Lack of sufficient evidence</p> <p>Date: 9/4/2015</p> <p>Facility number: 005051</p> <p>QA: cjl 09/17/15</p>	S 000		

Indiana State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE